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ABSTRACT

Because of administrative difficulties, therapeutic services provided at a nursing home by Project Adapt, through the St. Louis (Missouri) Regional Community Placement Program, were discontinued. At 2-month intervals, from June through December, 1986, 10 residents from the home where services were discontinued were compared with 10 and 15 residents at homes with continuous therapeutic programming, including individualized treatment plans (ITPs). Frequency comparisons and analysis of variance showed that behavioral changes resulting from continued psychogeriatric programming included improvement of a larger number and deterioration of a smaller number of clients. These changes were seen in behaviors that appeared more frequently in ITPs, but were related to facility-wide effects and not to the presence or absence of goals on particular ITPs. Two tables present study data, and the Client Observation Checklist is appended. (SLD)

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The Effect of Discontinuing Therapeutic Services on the Behavior of Nursing Home Residents

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Abstract. The St. Louis Regional Community Placement Program (CPP) purchases therapeutic programming from Project Adapt for residents at several nursing homes. Adapt services include consultation with facility administrators, inservice training for facility staff, development of Individualized Treatment Plans (ITPs), behavioral programs, and therapeutic group sessions. The current evaluation was planned when the authors learned that conflicts between administrators at one nursing home and Project Adapt would lead to the discontinuation of services after June 30, 1986. At 2 month intervals from June through December, 1986, residents of 3 nursing homes were rated on bathing, dressing and socialization: 10 clients at the facility where services were discontinued; and, 10 and 15 clients at 2 facilities with continuous programming. Frequency comparisons and analyses of variance led to the following conclusions:

1. behavioral changes occurred as a result of continued psychogeriatric programming, which included both:
   a. a larger number of clients improving; and,
   b. a smaller number of clients deteriorating;
2. these changes were limited to behaviors which appeared more frequently on ITPs; but,
3. behavioral changes were related to facility-wide effects and unrelated to presence or absence of goals on particular ITPs.

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The Effect of Discontinuing Psychogeriatric Services on Client Bathing, Dressing, and Socialization

The St. Louis Regional Community Placement Program (CPP) has purchased psychogeriatric rehabilitative programming from Project Adapt for residents at several nursing homes since 1983. Project Adapt services include consultation with facility administrators, inservice training for facility staff, development of Individualized Treatment Plans (ITPs), individual behavioral programs, and therapeutic group sessions. The discontinuation of services at one facility in July, 1986 provided the basis for evaluating the effect of Project Adapt on clients' bathing, dressing, and socialization.

In 1984, CPP expanded the number of facilities for which it purchased services from Project Adapt. That expansion of services led to using facility records for evaluating the extent and effect of medication changes (Fitz & Roos, 1984; Fitz & Simon, 1985A; Fitz & Simon, 1985B), incident reports (Fitz & Simon, 1984A), the use of restraints (Fitz & Simon 1984B), and bowel and bladder continence (Fitz, 1984C). Since there was no way to use facility records to evaluate client functioning in the important areas of bathing, dressing, and socialization, the Client Observation Checklist (COC) was developed (Fitz, 1984A). The COC (see Appendix A) has three rating components:

client self-bathing of four body areas;
six areas of self-dressing; and,
eight responses to a structured series of questions.

After it was developed, two pairs of raters averaged 94.44% and 95.37% agreement, establishing the reliability of the COC. Its validity was confirmed from correlations between COC bathing and dressing subscale ratings and independent casemanager ratings on the Treatment Setting Determination Survey of the same area, both of which exceeded .70 (Fitz, 1984A).

Fifteen clients at each of two nursing homes were rated with the COC at two month intervals between March and September, 1984. Project Adapt began services at Facility 1 after the first observation. Facility 2 did not begin receiving Project Adapt until after all observations were completed. By the fourth observation, all subscale means and change scores were in the direction of Project Adapt's having a positive influence, though none were statistically significant. However, a binomial test on the 18 COC items verified that clients at the facility with Project Adapt were more likely to improve or less likely to deteriorate (Fitz, 1984B).

Some important changes occurred after the 1984 data were collected. Project Adapt began at Facility 2 on May 20, 1985. Facility 1 closed down and all clients were moved to a different nursing home (which also will be referred to as Facility 1, to indicate continuity in the clients observed). Since the new Facility 1 did not receive Adapt services immediately, clients were without programming from November 1, 1984 through March 21, 1985. Finally, conflicts between nursing home administration and Project Adapt led to the discontinuation of programming at Facility 2 after June 30, 1986.

For the current study, clients were rated with the COC at two month intervals between June and December, 1986. Since it examines the effects of discontinuing Project Adapt, the current study is the obverse of the one in 1984;

1984 study:	Observation 1	Observation 2	Observation 3	Observation 4
Facility 1	No services	Adapt	Adapt	Adapt
Facility 2	No services	No services	No services	No services

1986 study:	Observation 1	Observation 2	Observation 3	Observation 4
Facility 1	Adapt	Adapt	Adapt	Adapt
Facility 2	Adapt	No services	No services	No services

The 1986 evaluation also included clients from a nursing home which has received Adapt programming uninterrupted since 1983. It will be referred to as Facility 3. Though there were 15 clients each at Facilities 1 and 2 during the 1984 study, at both facilities, 5 had been transferred or died by the end of 1986. At the beginning of the current study, 20 clients were observed at Facility 3; but, 5 had been transferred or died by the end of 1986. Complete data was gathered for 35 clients: 10 at Facility 1; 10 at Facility 2; and, 15 at Facility 3.

The second author observed clients the last week of June through the first week of July, the last week of August through the first week of September, the last part of October, and, the last part of December, 1986. After all observations were complete, the authors obtained ITPs from Project Adapt for Facilities 1 and 3 and from the CPP Casemanager for Facility 2. Though the observer was always aware of which nursing homes had received Project Adapt services, she was unaware of which clients had bathing, dressing, and/or socialization on their ITPs until the rating data was collected.

Once at the nursing home, the average time spent waiting to begin observing was 15.69 minutes and the average observation time was 21.24 minutes, for a total average time of 35.21 minutes per client. These are quite similar to the corresponding averages of 17.87, 19.67, and 37.60 minutes obtained during 1984 (Fitz, 1984A). In order to determine if there were differences between facilities or changes during the four observation times, these effects were contrasted in analyses of variance. Neither the main effect for the four observations nor the interaction between facility and observation was significant for any of the analyses, F's < 1.0 (waiting, observation, and total time). Though there was no facility main effect for waiting or total time, F's < 1.8, there was a significant facility main effect for observation time, $F(2,32) = 6.92$, $p < .005$. The rater felt that the longer time at Facility 3 (M=25.60 min) could have been due to a greater effort in having clients do things for themselves than at Facility 1 (M=19.52 min) and Facility 2 (M=16.40 min).

Results

The authors anticipated that the number of clients with each of the three COC goals on their ITPs would divide somewhat evenly at each facility. This would have allowed an analysis of whether clients with and without a given behavior on their ITP were more or less likely to improve for nursing homes which continued and discontinued Project Adapt programming. Since the number of clients with each goal on their ITP was zero for some facilities, it is necessary to report the findings as follows:

1. the frequency of goals on ITPs at each facility;
2. the mean ratings in each COC area by facility and observation;
3. the mean ratings at each facility according to presence or absence of COC goals; and,
4. the percentage of clients whose ratings changed from Observation 1 to Observations 2, 3, and 4.

Frequency of goals on ITPs

It was usually easy to determine the presence or absence of bathing and dressing on ITPs, though "hygiene" was usually written instead of "bathing". For some clients with Project Adapt, either bathing or dressing was emphasized more; but, both were included since Therapeutic Assistants work on both together. One client at the control facility who had "reduce bodily odor" on the ITP was included with those having "bathing" as a goal.

Goals such as "verbal interaction with staff and residents will improve" were tabulated as covering the same area as socialization on the COC. Adapt clients who had "recognition of people" on the ITP were not included as having a socialization goal; but, those with "interaction with others" were included. Since the socialization component of the COC consists of responses to direct questions, only goals which indicated social interaction were tabulated.

Table 1 demonstrates how ITP goals were differentially written for clients according to facility. Bathing more often appeared on ITPs written by Project Adapt (72%) than the other facility (30%), $\chi^2(1) = 5.25$, $p < .05$; dressing also appeared more often on Adapt (72%) than non-Adapt ITPs (0%), $\chi^2(1) = 14.82$, $p < .001$; but, socialization was on non-Adapt (60%) more often than Adapt ITPs (12%), $\chi^2(1) = 8.62$, $p < .01$.

The fact that no clients at Facility 2 had dressing on their ITPs and no clients at Facility 1 had socialization on their ITPs made it impossible to do an overall analysis of Facility (1, 2, & 3) by ITP (presence or absence) by Observation (1, 2, 3, & 4). Therefore, analyses for Facility (3) by Observation (4) were done for each of the COC components. When some clients at a given facility had the particular behavior on their ITPs, an ITP by Observation analysis was done.

Mean ratings: Facility by Observation analyses

Bathing. The analysis of variance revealed the following:

no main effect for facility, $F < 1.0$;
no main effect for observation, $F < 1.0$; but,

a highly significant interaction between facility and observation, $F(6,96) = 3.82$, $p = .002$.

While no nursing home had higher scores than the others, those with Adapt usually had higher ratings in the later observations while bathing ratings for clients where Project Adapt was discontinued were lower for all three later ratings.

Dressing. The analysis of variance revealed the same pattern for dressing:

no main effect for facility, $F = 1.68$, n.s.;
no main effect for observation, $F = 1.06$, n.s.; but,
a significant facility by observer interaction, $F(6,96)=2.46$, $p < .03$.

Again, no facility had significantly higher scores; but, those with Adapt usually had higher mean ratings during the later observations, while the other facility always had lower ratings after programming was discontinued.

Socialization. The analysis of variance revealed the following:

no main effect for facility, $F < 1.0$;
no main effect for observation, $F < 1.0$; but,
an almost significant facility by observation interaction, $F(6,96)=2.08$, $p < .07$.

In contrast to the results for bathing and dressing, higher scores did not correspond with continued Adapt programming: at Facility 1 (Adapt), all later mean ratings were higher than for the initial observation; at Facility 3 (Adapt), all later mean ratings were lower than for the initial observation; but, at Facility 2 (services discontinued) the initial mean rating was in between the subsequent ratings.

Mean ratings: Presence or absence of goals on ITPs

Separate analyses were done for facilities at which COC goals appeared on some ITPS.

Bathing. At Facility 1 (Adapt), where 6 of 10 clients had bathing on their ITPs, there was no main effect for ITP, $F < 1.0$, no main effect for observation, $F < 1.4$, n.s., and no interaction, $F < 1.4$, n.s. At Facility 2 (discontinued services), where 3 of 10 clients had bathing on their ITPs, there was no main effect for ITP, $F < 1.0$, and no interaction, $F < 1.0$. Though the main effect for observation did not reach conventional levels of significance, $F(3,24) = 2.28$, $p < .11$, it suggested decreasing ratings for self-bathing regardless of whether the goal appeared on the ITP. At Facility 3 (Adapt), where 12 of 15 clients had bathing on their ITPs, there was no main effect for ITP, $F < 1.0$, no main effect for observation, $F = 1.44$, n.s., and no interaction, $F < 1.2$, n.s.

Dressing. Only those nursing homes with continuous Project Adapt services had clients with dressing on some ITPs. Analyses of variance for both revealed no main effects or interactions, $Fs < 1.0$.

Socialization. No Facility 1 clients had socialization on their ITPs. At Facility 2, where 6 of 10 clients had socialization as a goal, the analysis of variance revealed no main effects or interactions, $Fs < 1.1$, n.s. At Facility 3, where 3 of 15 ITPs included socialization, there was no main effect for ITP, $F < 1.9$, n.s., and no interaction, $F < 1.0$; but, a near-significant main effect for observation, $F(3,39) = 2.80$, $p < .06$, reflecting lower ratings during later observations.

Frequency of behavioral changes from Observation 1 to Observations 2, 3, & 4

Table 2 clarifies the source of contrasting mean ratings at different facilities. It presents the percent of clients whose rated bathing, dressing, and socialization improved, showed no change, or deteriorated during the time of observation. Observation 1 is used as a baseline against which Observations 2, 3 and 4 are compared. Since the presence or absence of goals on the ITP never affected mean ratings, Table 2 reports the percentage of change only according to nursing home.

The following patterns characterize both bathing and dressing:

during each observation period, both facilities with Adapt had a higher percentage of clients improving than did the facility where programming was discontinued; and,
during each observation period, both Adapt facilities had a lower percentage of clients deteriorating than did the facility where programming was discontinued.

However, there was no clear pattern for socialization. Facility 1 usually had a higher percentage of clients improving and a lower percentage deteriorating than did the facility with discontinued services. But Facility 3 (Adapt) consistently had the lowest percentage of clients improving and the highest percentage who were deteriorating. When Facilities 1 and 3 are combined, the pattern is still not consistent, though it does suggest that Project Adapt had more improvement and less deterioration by the fourth observation.

Conclusions

A similarly designed evaluation of Project Adapt during 1984 found a small, but positive effect of initiating psychogeriatric programming. The current evaluation found a much stronger effect from discontinuing such services. This suggests that clients may need a relatively long time before they begin showing a positive reaction to programming, but that they do not take such a long time to react when services are withdrawn.

There needs to be some explanation to appreciate the major finding of the evaluation, that clients at nursing homes with continuous services from Project Adapt showed more improvement and less deterioration in the areas that frequently appeared on ITPs (bathing and dressing) than did clients at the nursing home where services were withdrawn. It may seem that more improvement and less deterioration are two ways of saying the same thing. They are not. It is possible that more clients would improve at one nursing home but that the same number would deteriorate at each. This would happen if one nursing home had more clients in the "no change" category. It is also possible that the same nursing home could have both more clients who improved and more who deteriorated. This could happen if the other facility had a very large number

in the "no change" category. That this would not be an anomalous finding is confirmed by the seemingly paradoxical effect reported by Fitz & Simon (1985B) that Project Adapt clients were both more likely to have more medication increases and more medication decreases following initiation of programming. This occurred because the "waiting list" clients had very few medication changes.

In other words, the continuation of Project Adapt programming did, in fact, have two different (though closely related) effects:

1. it increased the percentage of clients who improved their self-bathing and self-dressing skills; and,
2. it decreased the percentage of clients whose self-bathing and self-dressing skills deteriorated.

It is important that the opposite of this did not occur for the behavioral area which was more frequently on the ITPs of clients in the nursing home where services were withdrawn. Though clients at Facility 2 more often had socialization on their ITPs, they did not systematically show more improvement or less deterioration -- they showed no significant difference from clients at the nursing homes with continued Adapt services.

The fact that no observed clients at one facility had a dressing goal and no observed clients at another facility had a socialization goal was totally unexpected. The reason that only 12% of Adapt clients had socialization goals may be that, during 1986, Project Adapt initiated a Family Outreach Program and made more extensive efforts to involve clients in the community. This social behavior apparently supplanted the more basic skill of verbal interaction, which is measured by the CDC's socialization component. The lower and inconsistent scores for Adapt clients on socialization suggests that community integration cannot substitute for direct training in social interaction. Project Adapt should consider the possibility that training in these more basic skills might make community integration more successful. A client who responds when a stranger talks to him/her is certainly more likely to be accepted in the community.

It was also quite unexpected that the presence or absence of bathing, dressing, and socialization goals on the ITP would have nothing to do with clients' functioning. The fact that the anticipated interaction between presence/absence of ITP goal and observation failed to materialize on any of the seven analyses certainly indicates that the effect does not exist. This suggests that Project Adapt has a global effect of improving overall functioning at a facility, rather than particular effects for individual clients. And, this would indicate some need for more carefully individualized programs for clients. It should not be overlooked that ITPs also failed to affect client behavior at the nursing home where Project Adapt services were withdrawn.

The conclusions from this report can then be stated as follows:

1. behavioral changes occurred as a result of continued psychogeriatric programming, which included both:
   a. more improvement; and,
   b. less deterioration;
2. these changes were limited to behaviors which more frequently appeared on ITPs; but,

3. behavioral changes were related to facility-wide effects and unrelated to presence or absence of goals on particular ITPs.

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TABLE 1

FREQUENCY OF CLIENTS WITH BATHING, DRESSING, & SOCIALIZATION GOALS ON THEIR ITP BY FACILITY

	ON ITP		NOT ON ITP		TOTAL	
	N	%	N	%	N	%
BATHING						
FACILITY 1 (ADAPT)	6	60%	4	40%	10	100%
FACILITY 2 (CONTROL)	3	30%	7	70%	10	100%
FACILITY 3 (ADAPT)	12	80%	3	20%	15	100%
ADAPT FACILITIES (1 & 3)	18	72%	7	28%	25	100%
DRESSING						
FACILITY 1 (ADAPT)	6	60%	4	40%	10	100%
FACILITY 2 (CONTROL)	0	0%	10	100%	10	100%
FACILITY 3 (ADAPT)	12	80%	3	20%	15	100%
ADAPT FACILITIES (1 & 3)	18	72%	7	28%	25	100%
SOCIALIZATION						
FACILITY 1 (ADAPT)	0	0%	10	100%	10	100%
FACILITY 2 (CONTROL)	6	60%	4	40%	10	100%
FACILITY 3 (ADAPT)	3	20%	12	80%	15	100%
ADAPT FACILITIES (1 & 3)	3	12%	22	88%	25	100%

Table 2. PERCENTAGE OF CLIENTS WITH BEHAVIOR CHANGES BY FACILITY

	BATHING						DRESSING						SOCIALIZATION					
	OBS2		OBS3		OBS4		OBS2		OBS3		OBS4		OBS2		OBS3		OBS4	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
FACILITY 1 (ADAPT)																		
IMPROVEMENT	2	20.0%	5	50.0%	3	30.0%	4	40.0%	3	30.0%	3	30.0%	4	40.0%	3	30.0%	6	60.0%
NO CHANGE	5	50.0%	5	50.0%	4	40.0%	4	40.0%	5	50.0%	5	50.0%	3	30.0%	5	50.0%	2	20.0%
DETERIORATION	3	30.0%	0	0.0%	3	30.0%	2	20.0%	2	20.0%	2	20.0%	3	30.0%	2	20.0%	2	20.0%
TOTAL	10	100.0%	10	100.0%	10	100.0%	10	100.0%	10	100.0%	10	100.0%	10	100.0%	10	100.0%	10	100.0%
FACILITY 2 (CONTROL)																		
IMPROVEMENT	1	10.0%	0	0.0%	1	10.0%	0	0.0%	0	0.0%	0	0.0%	3	30.0%	4	40.0%	2	20.0%
NO CHANGE	5	50.0%	4	40.0%	4	40.0%	7	70.0%	5	50.0%	7	70.0%	3	30.0%	4	40.0%	3	30.0%
DETERIORATION	4	40.0%	6	60.0%	5	50.0%	3	30.0%	5	50.0%	3	30.0%	4	40.0%	2	20.0%	5	50.0%
TOTAL	10	100.0%	10	100.0%	10	100.0%	10	100.0%	10	100.0%	10	100.0%	10	100.0%	10	100.0%	10	100.0%
FACILITY 3 (ADAPT)																		
IMPROVEMENT	5	33.3%	7	46.7%	4	26.7%	8	53.3%	4	26.7%	7	46.7%	4	26.7%	2	13.3%	3	20.0%
NO CHANGE	8	53.3%	6	40.0%	4	26.7%	3	20.0%	7	46.7%	4	26.7%	2	13.3%	3	20.0%	3	20.0%
DETERIORATION	2	13.3%	2	13.3%	7	46.7%	4	26.7%	4	26.7%	4	26.7%	9	60.0%	10	66.7%	9	60.0%
TOTAL	15	100.0%	15	100.0%	15	100.0%	15	100.0%	15	100.0%	15	100.0%	15	100.0%	15	100.0%	15	100.0%
ADAPT FACILITIES (1 & 3)																		
IMPROVEMENT	7	28.0%	12	48.0%	7	28.0%	12	48.0%	7	28.0%	10	40.0%	8	32.0%	5	20.0%	9	36.0%
NO CHANGE	13	52.0%	11	44.0%	8	32.0%	7	28.0%	12	48.0%	9	36.0%	5	20.0%	8	32.0%	5	20.0%
DETERIORATION	5	20.0%	2	8.0%	10	40.0%	6	24.0%	6	24.0%	6	24.0%	12	48.0%	12	48.0%	11	44.0%
TOTAL	25	100.0%	25	100.0%	25	100.0%	25	100.0%	25	100.0%	25	100.0%	25	100.0%	25	100.0%	25	100.0%

NOTE. 'OBS2,' 'OBS3,' AND 'OBS4' REFER TO CHANGES FROM OBSERVATION 1 TO OBSERVATIONS 2, 3, & 4, RESPECTIVELY.

Appendix A

A.T. _____

B.O.T. _____

E.O.T. _____

CLIENT OBSERVATION CHECKLIST

Client Name: _____ Facility _____ Date _____

Client ID: _____ Rater _____

I. BATHING CHECKLIST (sum = _____pts.)
(washing & drying)

	No	Part	Yes
1. Neck, Mouth, Rest of face	0	1	2
2. Hands & Arms	0	1	2
3. Chest & Groin	0	1	2
4. Feet & Legs	0	1	2

II. DRESSING CHECKLIST (sum = _____pts.)

1. Selected own clothes	0	1	2
2. Put on underclothes	0	1	2
3. Put on clothes	0	1	2
4. Zipped, Buttoned, Snapped, Hooked	0	1	2
5. Put on socks/nylons	0	1	2
6. Put on shoes	0	1	2

III. SOCIALIZATION CHECKLIST (sum = _____pts.)

RATER INTRODUCES SELF	No	Part	Yes
1. "What's your name?"	0	1	2
2. "What's the aide's name?"	0	1	2
3. "What sort of things do you do here?"	0	1	2

SHORT PAUSE

4. Has the client initiated any conversation with you by this time?	0	1	2

AFTER THE FIRST 3 SET QUESTIONS YOU MAY CONVERSE WITH THE CLIENT ON ANY TOPIC. COMPLETE THE FOLLOWING AFTER THE CLIENT HAS BEEN DRESSED.

5. Did the client initiate conversation with you at any point?	0	1	2
6. Did the client ever answer anything you asked?	0	1	2
7. Was the client willing to have eye contact with you?	0	1	2
8. Did the client initiate conversation with anyone?	0	1	2

COMMENTS:

STANDARDS FOR CLIENT OBSERVATION CHECKLIST

ABBREVIATIONS: A.T. = Arrival Time - On the first client observation check list, mark the time you arrived at the home. On successive checklists, mark the time your last checklist was completed.

B.O.T. = Beginning Observation Time - The time you begin the checklist.

E.O.T. = Ending Observation Time - The time the checklist is completed.

I. BATHING CHECKLIST

NO = unable or refused to perform the task.
PART = required assistance or verbal cues to perform the task.
YES = independently performed the task.

PLEASE NOTE: IF A SPECIAL CLEANING PROBLEM EXISTS, (i.e., COLOSTOMY, FACIAL WOUND, ETC.) THE CLIENT SHOULD BE ABLE TO CLEAN APPROPRIATELY IN ORDER TO RATE AS "YES."

*Specific examples for "PART"

1. missed neck, mouth or rest of face
2. missed a hand or arm
3. missed chest or groin
4. missed a foot or leg

II. DRESSING CHECKLIST

NO = unable or refused to perform the task.
PART = required assistance or verbal cues to perform the task or started, but did not complete the task.*(see below)
YES = independently performed the task.

*Specific examples for "PART".

1. can choose one or more appropriate items of clothing, or chooses all daily wear, but not suitable to the climate.
2. inside out or backwards
3. inside out or backwards
4. buttons or snaps wrong hole
5. inside out
6. wrong feet or can not tie laces

III. SOCIALIZATION CHECKLIST

Rating should be done according to how the client responds to the interview during the bathing and dressing observations.

QUESTIONS 1, 2, 3

NO = ignored, unable or refused to respond
PART = begins a response but stops, or responds to a verbal prompt by other staff, or communicates nonverbally (ie, headshake), or with non-English vocalization (ie, grunt)
YES = any coherent response even if answer is incorrect

QUESTION 7

NO = no eye contact.
PART = glanced at rater one or more times, but did not maintain eye contact for longer than a second.
YES = maintained eye contact for longer than a second.

DEFINITION: Initiate conversation - any coherent, logical sequence of two or more words requiring a response from someone.